Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOUSTON NW MEDICAL CENTER
P O BOX 75284
DALLAS TEXAS 75284

Respondent Name

TOMBALL REGIONAL HOSPITAL

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-11-3052-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Creative Risk denied this claim for no authorization. We previously requested a reconsideration to Creative Risk Fund due to mitigating circumstances and Creative Risk Fund has maintained its administrative denial." "**Please be advised, this patient injured herself at work. She presented to the ER on 9/27/2010 after a sudden movement that caused severe excruciating pain. The admission records reveals that the patient was unable to stay awake, our client was unable to obtain signatures and was admitted as self-pay, uninsured and unemployed. It was later determined, after consultation with the patient that she was injured at work. After this new information was received, our client contacted the patients employer on 9/28/2010 and per Rosa Gutierrez, the HR rep for Tomball, she had just received the incident report and no claim number was available yet. She had swelling to her bilateral extremities and she was not able to get relief from the previously prescribed pain medications. She is also a diabetic and unable to take her diabetes medicine due to the pain caused by her work related injury. The patient's pain could not be controlled in the ER and she was admitted for pain control. As the injury was clearly the result of a work related injury for which Creative Risk is responsible, Creative Risk has suffered no harm as a result of the lack of pre-certification as it is evidence based on the medical records, a pre-certification would have been approved has the patient provided the correct insurance information at the time of admission.**" "The enclosed medical records clearly support the appropriateness of the treatment…"

Amount in Dispute: $7,382.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Although Requestor asserts that it did not initially appreciate that claimant's treatment was subject to workers' compensation considerations, it is apparent by Requestor's own admission, that it both consulted with Claimant about the work-related nature of her injury and contacted the Human Resources representative for Respondent prior to performing surgery. Yet, Requestor made no attempt to inquire about or follow through with the need to request preauthorization for surgery. Moreover, contrary to Requestor's assertion, its failure to request preauthorization for Claimant's surgery was not due to confusion about her coverage as its Admission Record for claimant clearly denotes that payor to be 'Workers' Comp Adm' and even lists the contact information for Respondent's third-party workers' compensation administrator (see Exhibit A attached). Certainly, Requestor, as a sophisticated heath care facility, should have appreciated that this was a workers' compensation matter and that spinal surgery would be subject to preauthorization." "In summary, Requestor made no attempt to obtain preauthorization prior to performing spinal surgery on Claimant. Very

simply, it did not follow the steps provided in the applicable rules and statutory provisions to obtain preauthorization or Division approval for surgery prior to performing the spinal surgery. Consequently, in this situation, where preauthorization was required but not requested, Respond is not liable for the costs of treatment."

Response Submitted by: Creative Risk Funding, 8111 Lyndon B. Johnson Freeway, Suite 795, Dallas, Texas 75251

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 27, 2010 through September 29, 2010	Inpatient Hospital Surgical Services	$7,382.80	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
   (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 11, 2010
   - 197 –Payment denied/reduced for absence of precertification/authorization.
   - 198 –Payment denied/reduced for exceeded precertification/authorization.
   - 50 –These are non-covered services because this is not deemed a medical necessity by the payer.

   Explanation of benefits dated December 17, 2010
   - 197 –Payment denied/reduced for absence of precertification/authorization.
   - 198 –Payment denied/reduced for exceeded precertification/authorization.
   - 50 –These are non-covered services because this is not deemed a medical necessity by the payer.
   - 193 –Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W4 –No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Did the requestor meet the requirements for a medical emergency in accordance with 28 Texas Administrative Code §180.22 and §133.2?
2. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
3. Did the requestor meet the requirements for medical necessity in accordance with 28 Texas Administrative Code §134.600?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §180.22(c) states, in pertinent part, that "The treating doctor shall: (1) except in the case of an emergency, approve or recommend all health care rendered to the employee…" 28 Texas Administrative Code §133.2(3)(A)(i-ii) states, "a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, included severe pain , that the absence of immediate medical attention could reasonably be expected to result in…placing the patient's health or bodily functions in serious jeopardy, or serious dysfunction of any body organ or part." Review of the respondent's submitted Admission Record supports their position that the requestor was aware that this was a work related injury/admission . The requestor has not supported the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health or bodily functions in serious jeopardy, or serious dysfunction of a body organ or part. The Division finds that, having not demonstrated a case of emergency, the requestor has not met the exception to the requirement that the treating doctor shall approve or recommend all health care rendered to the employee. Review of the submitted documentation finds no evidence to support a medical emergency. The Division concludes that the respondent's assertion that the disputed service was not a medical emergency is supported.
2. Per Texas Labor Code, Section §413.011(b) "the insurance carrier is not liable for those specified treatment and services unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or order by the commission." 28 Texas Administrative Code, Section §134.600(c)(1)(b) states, "The carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury…only when the following situations occur…preauthorization of any heath health care listed in subsection (p) of this section was approved prior to providing the health care." 28 Texas Administrative Code, Section 134.600(h)(2) effective January 1, 2003, requires preauthorization for "outpatient surgical or ambulatory surgical services, as defined in subsection (a) of this section." Review of the submitted documentation finds no evidence to support that the provider obtained preauthorization for the disputed services prior to providing the health care. The Division concludes that the respondent's denial reason that the requestor did not obtain preauthorization approval prior to providing the health care in dispute is supported.
3. The respondent denied reimbursement for the disputed services based upon "50- These are non-covered services because this is not deemed a medical necessity by the payer." Division rule at 28 TAC §134.600(h)(2) effective January 1, 2003, requires preauthorization for "outpatient surgical or ambulatory surgical services, as defined in subsection (a) of this section." The Division concludes that the respondent's denial that the disputed service was not medically necessary is supported.
4. Review of the submitted documentation finds that the requestor did not submit documentation to support a medical emergency as defined in Division rule at 28 TAC §133.2. Review of the submitted documentation finds that the Requestor did not submit documentation to support preauthorization approval was obtained prior to providing the services in dispute in accordance with Division rule at 28 TAC §134.600. Therefore, reimbursement is not recommended

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $ 0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 7, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.